HOMELESS CHILDREN'S NETWORK

REFERRAL FOR SERVICES

Date Submitted: ____________________

Client's Name: ____**DOB:** ________________

Preferred Name: ____

MediCal Number or SSN: _______________________________________(Required for EPSDT programs)

(medi-cal # usually begins with a "9" and always includes a letter)

(If minor) Caregiver's Name/ Relationship: ____

Client's Address/Location: ____

Client/Caregiver Contact: ____

Client Availability for Services (Days/Times): ____

REASON FOR REFERRAL Issues that child/client/family members are facing (in their words or as you observe)**:**

____

____

Has the client/family witnessed an act/s of Violence in the home, school or community that has significantly impacted the client/family's life? Please check one**: Yes___No____**

If "Yes" briefly describe: ____

Specific needs or concerns (i.e. language/disability)? ____

***Is the client/family seeking cultural specific/relevant therapeutic services? Yes________No____**

If "Yes", please describe:____

Is there anyone in this family who has been a client of HCN (past/present)? Yes________No____

If "YES", Name(s):____

Child's School/Care Center: ____

Is the client receiving SPED Services? Check all that apply: ⬜ **IEP** ⬜ **ERMHS** ⬜ **SDC**

Referred by: _________________________________Agency Name: ________________________________

Title: __________________________Phone: _____________________Email: ______________________

Program: ⬜ **General EPSDT** (Mental Health/ Behavioral Health services) ⬜ **Ma'at EPSDT** (Afri-centric MH services)

Brighter Futures: ⬜**Individual** ⬜**Group** (Therapeutic Service for fathers who identify with the black/african diaspora)

⬜**Training Program** (School-based internship services) ⬜**Child-Parent Psychotherapy (age 0-6)**

***Email referrals to clientreferrals@hcnkids.org or Fax to (415) 437-3994**

**Please note that while we will do our best to match client/family needs, matching is not guaranteed.*

CONFIDENTIAL